44/22/77 [2]

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THE PRESIDENT HAS SEEN.

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

ASSISTANT SECRETARY

See Info

April 22, 1977

MEMORANDUM FOR THE PRESIDENT

Subject: Status of Tax Provisions in the Economic Stimulus Bill

This memorandum deals with the tax portion of the economic stimulus package now being considered on the Senate floor. Although final Senate action is not expected until early next week, it now appears that the following provisions will be considered by the House-Senate conferees. (The rebate proposal is not mentioned in view of the fact that the Senate has now deleted it and the House is expected to agree to this change. In addition, the extension of existing tax cuts--$7.8 billion--is omitted because this is in both bills and there is no argument on this.)

The full year revenue loss for the principal components of the bills would be:

	House	Senate
	(in billions)	
Individual Tax Cnts (standard deduction changes, but ignoring rebate)	-$5.2	-$6.0
Business Tax Cuts	-$2.4	-$2.9
Miscellaneous Provisions	--	-$0.4
Total	-$7.6	-$9.3

The provisions referred to above are analyzed briefly below:

A. Standard Deduction Changes for Individuals	Revenue Effect FY 1977/Full Year (in billions)	
House--The House bill has a flat standard deduction of $2,400 for single individuals and $3,000 for married couples filing joint returns. (Under existing law the standard deduction ranges from a minimum of $1,700 for single returns and $2,100 for joint returns to a maximum of $2,400 and $2,800, respectively.)	-$1.8	-$5.2

ok

THE WHITE HOUSE
WASHINGTON

April 22, 1977

Stu Eizenstat

The attached was returned in the President's outbox. It is forwarded to you for appropriate handling.

Rick Hutcheson

Re: Status of Tax Provisions in the Economic Stimulus Bill

THE WHITE HOUSE
WASHINGTON

ACTION	FYI	
		MONDALE
		COSTANZA
	☑	EIZENSTAT
		JORDAN
		LIPSHUTZ
		MOORE
		POWELL
		WATSON

	ENROLLED BILL
	AGENCY REPORT
	CAB DECISION
	EXECUTIVE ORDER

Comments due to Carp/Huron within 48 hours; due to Staff Secretary next day

	FOR STAFFING
	FOR INFORMATION
☑	FROM PRESIDENT'S OUTBOX
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	IMMEDIATE TURNAROUND

		ARAGON
		BOURNE
		BRZEZINSKI
		BUTLER
		CARP
		H. CARTER
		CLOUGH
		FALLOWS
		FIRST LADY
		GAMMILL
		HARDEN
		HOYT
		HUTCHESON
		JAGODA
		KING

		KRAFT
		LANCE
		LINDER
		MITCHELL
		POSTON
		PRESS
		B. RAINWATER
		SCHLESINGER
		SCHNEIDERS
		SCHULTZE
		SIEGEL
		SMITH
		STRAUSS
		WELLS
		VOORDE

	FY 1977	Full Year
Senate--The Senate bill has a flat standard deduction of $2,200 for single individuals and $3,200 for heads of households and married couples filing joint returns.	-$2.0	-$6.0
Comment--The Administration proposed a flat standard deduction of $2,200 for single individuals and $3,000 for married couples filing joint returns. Although both Houses have accepted the "flat standard deduction" concept proposed by the Administration, the Senate version is preferable because it reduces the "marriage penalty" relative to the House bill. The Conference Committee might compromise on $2,300 for singles and $3,100 for couples.		
B. Business Tax Credits		
House--The House bill has a jobs credit generally equal to 40 percent of the first $4,200 of wages paid subject to the Federal Unemployment Tax Act (FUTA). However, this credit would apply only to the extent an employer increased its employment by at least 3 percent over the prior year (this is the "incremental" aspect of the credit). The credit can not exceed $40,000 a year (this is the cap and means it covers only 24 employees per employer).	-$0.7	-$2.4
Senate--The Senate bill has an optional business credit. The taxpayer may choose between (1) an additional 2 percent investment credit (for a total investment credit of generally 12 percent) or (2) a jobs credit similar to the one approved by the House, but at a 50 percent rate on the first $4,200 of FUTA wages and an annual credit ceiling of $100,000 (this covers 48 employees per employer). The 50 percent rate and the $100,000 cap were added on the Senate floor.	-$1.1	-$2.9

FY1977 Full Year

Comment--With the jobs credit in both bills the Conference Committee will have to approve a jobs credit--either separately or as an alternative to the 12 percent investment credit passed by the Senate. The best resolution we can hope for is a jobs credit along the lines of the House bill, either with or without an optional 2 percent investment tax credit. The full-year revenue loss from such a proposal could range from about $2.2 billion to about $2.9 billion. The jobs credit, despite our continued opposition, is very popular in both the House and Senate because they believe (we disagree) it will provide new jobs. Small business also supports it.

C. Miscellaneous Provisions in the Senate Bill

The Senate bill has several additional provisions, most of which seek to modify the impact of the Tax Reform Act of 1976. The most important of these are summarized below. We also anticipate that additional amendments might be added on the Senate floor.

(1) The bill would eliminate the intereet and penalties resulting for 1976 from retroactive changes made by the 1976 Act. -$0.015

Comment--This change is a desirable one which in separate legislation we have supported.

(2) The 1976 Act substantially restricts the extent to which employees can receive sick pay on a tax-free basis. This change took effect on January 1, 1976. The Senate bill would postpone the effective date until January 1, 1977. -$0.327

	FY1977	Full Year
Comment--The Treasury Department did not support this provision in separate legislation, primarily because of its revenue loss in fiscal year 1977 ($327 million) and because of administrative problems arising from making this change in tax law for 1976 at this late date. Nevertheless, this amendment has overwhelming support in both Houses and among representatives of organized labor. It would be difficult to oppose.		
(3) The 1976 Act restricts the extent to which overseas workers can exclude their earned income from U.S. taxation (under Code section 911). The Senate bill would postpone the effective date of this change from January 1, 1976 to January 1, 1977.	-$0.038	
Comment--The Treasury Department has opposed this change for reasons similar to those stated with respect to the sick pay provisions. However, support for this provision, although strong, is not as overwhelming as for the sick pay exclusion.		
(4) As a result of changes made by the 1976 Act, gambling winnings of more than $1,000 are now subject to withholding at a 20 percent rate. In the case of sweepstakes, wagering pools, and certain lotteries, this withholding requirement applies regardless of the odds. We understand that an amendment will be offered on the Senate floor to eliminate the withholding requirement on gambling winnings from horse races, dog races, and jai alai unless the odds are at least 300 to 1.	(less than) -$0.010	(less than) -$0.010
Comment--This amendment represents a compromise that Treasury staff has discussed with staff members on the		

Hill. We believe it is acceptable, especially in view of the fact that it would retain the requirement that a race track must report winnings of over $600 to the IRS.

Sincerely,

Larry Woodworth

Laurence N. Woodworth
Assistant Secretary
for Tax Policy

Distribution of Tax Cut Between Individuals and Business

In terms of fiscal year budget receipts, the tax cut is distributed as follows:

	(billions of dollars) FY 77	FY 78
Senate bill		
Individuals:		
Standard deduction	1.5	8.1
Extension of general tax credit	-	5.5
Extension of earned income credit	-	1.3
Sick pay, foreign income, etc.	0.4	-
Total individual	1.9	14.9
Business:		
Jobs credit	0.7	1.7
Investment credit	0.4	1.2
Extension of small business cuts	-	1.0
Total business	1.1	3.9
Total tax cut	3.0	18.9
House bill (without rebate)		
Individuals	1.4	15.0
Business	0.7	3.4
Total	2.1	18.4

In terms of tax liability for calendar year 1978, the year in which the tax cuts are fully effective, the tax cuts are distributed as follows:

	(billions of dollars)	
Senate bill		
Individuals:		
Standard deduction	6.0	6.0
Extension of earned income credit	1.3	
Extension of general tax credit	10.7	
Total individual	18.0	
Business:		1.2
Investment credit	1.2	1.7
Jobs credit	1.7	
Extension of small business cuts	2.3	2.9
Total business	5.2	
Total	23.2	
House bill		
Individuals	17.0	
Business	4.7	
Total	21.7	

THE WHITE HOUSE
WASHINGTON

April 22, 1977

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Rick Hutcheson

cc: Frank Moore
Jack Watson
Peter Bourne

Re: Health Message

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WASHINGTON

ACTION	FYI	
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		COSTANZA
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	ENROLLED BILL
	AGENCY REPORT
	CAB DECISION
	EXECUTIVE ORDER

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		WELLS
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THE WHITE HOUSE
WASHINGTON

Mr. President:

Comments from Watson and Bourne, and memos from Califano on the CHAP program and cost containment are attached.

The message is scheduled to go to the Hill on Monday. Frank would like to be able to take advance copies of the message to key Members of Congress today, if you approve the message.

TWO SIGNATURES REQUESTED on

the attached Message to Congress.

--Rick

THE WHITE HOUSE
WASHINGTON

4-22-77

Stu -

See Watson/Parham memo: a) (1) ok to add
b) Either delete (2) or modify language as indicated.

Also add brief sharp paragraph discouraging unnecessary use of hospital facilities & services.

Otherwise ok.

J

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR: THE PRESIDENT

FROM: STU EIZENSTAT
JOE ONEK
BOB HAVELY

SUBJECT: Health Message

Attached is the health message, summaries of the hospital cost containment and children's health legislation, and memoranda from Secretary Califano containing analyses of the two bills. Our views below incorporate OMB's positions and analysis. The message has been reviewed and improved by Jim Fallows' staff and has been approved by HEW.

I. Cost Containment.

Forty percent of all health spending goes for hospitalization. Hospitals are by far the largest component of the health sector, as well as the fastest growing (15 percent per year, as opposed to the annual CPI increase of six percent). While a long-term prospective reimbursement system is being prepared, the cost containment program will restrain increases in the reimbursements which hospitals receive from all sources: Medicare, Medicaid, Blue Cross, commercial insurers, and individuals. The limit will be set using a formula which not only reflects general inflation, but also extends an additional allowance to hospitals for improving the quality of their care. Based on current trends, the limit for FY 1978 will be approximately nine percent.

The legislation also establishes a limit on new capital investment by hospitals. This limit will be allocated to the states through a population-based formula. Further, the construction of new hospital beds will be prohibited in areas where excess bed capacity exists. These capital expenditure provisions will have little or no FY 1978 budget impact, but they are crucial to long-term cost containment.

A. Wage Pass-through. The legislation contains a pass-through for all wage increases above the nine percent limit granted to non-supervisory employees. The pass-through terminates in 18 months, unless the Secretary of HEW certifies that it should continue. Organized labor demanded a wage pass-through, and threatened to oppose the bill if such a provision were not included. CEA Chairman Schultze originally opposed the pass-through as inconsistent with the Administration's anti-inflation policy, but he has since withdrawn his objection.

The wage pass-through will allow hospitals to collect increased reimburaements to a small, but not precisely predictable, extent. In addition, its presence may generate pressure ou the Hill for other pass-throughs -- for energy costs, for example. On balance, however, we believe the advantage of avoiding union opposition to our entire cost containment effort is worth these risks. OMB also believes that although the pass-through lacks programmatic merit, it is politically necessary.

B. The Role of the States. The hospital reimbursement limit will be administered by the federal government. The few states with on-going cost containment programs will be able to continue their own regulatory approaches if they meet the federal program's objectives. The states will also play major roles in the exceptions process and in allocating capital expenditures. Further, the legislation permits states to impose limits on Medicaid more rigorous than the federal limitations. Any greater state role would encounter organized labor's autipathy toward state regulation. Although some Governors may argue for a broader state role, we believe the federal/state balance in the bill is correct, both substantively and politically.

II. Child Health Assessment Program (CHAP).

You have previously approved the broad outlines of the CHAP program, which modifies the existing EPSDT program. HEW's specific legislative proposal is within the estimates in your 1978 budget. The legislatiou would raise from 55 percent to over 75 percent the average federal payment to the states for health care provided to children whose health needs are assessed under the program. Second, it extends benefits to children under age six whose family income makes them eligible for assitance but who do not meet additional state eligibility requirements. Finally, it encourages states to assure the availability of comprehensive health providers for low-income children. Projected FY 1978 cost: $155 million; FY 1981: $382 million.

A. Limited Extension of Eligibility. The legislation extends eligibility only to low-income children under age six. However, if eligibility were extended to all low-income children under age 21, this change would add $120 million to the federal budget in 1978 and approximately $40 million to state Medicaid budgets. OMB is concerned that the Congress may pass this extension, thereby increasing federal expenditures in 1978 through 1981. HEW counters that this is unlikely because the states will strenuously object, and because the Congressional budget limits will make such additions difficult. We believe HEW is correct.

B. Other Issues. OMB also points out that the HEW proposal commits the federal government to a 75 percent match for certain Medicaid services, and is concerned that this step will be a precedent for a higher federal share for all Medicaid services. OMB would like to consider alternatives, such as an annual $180 million children's health grant program to the states. You have previously approved this increased match.

C. Summary. OMB suggests that the health message either exclude reference to CHAP, or refer only generally to it and allow time for additional work on the program. However, unless we go forward with CHAP the Administratiou's health initiatives will be limited to cost containmeut. Furthermore, given the Congressional budget deadlines, little additional time remains in any case for further work on the program.

HEW maintains that this program is necessary to fulfill an important commitment of yours. While this legislation and the process that produced it have been far from perfect, we agree. We believe OMB's objections are not major, and suggest we proceed with the health message with the CHAP program intact.

III. Procedures.

A. Press Briefing. Current plans call for Secretary Califano to anuounce these programs Monday moruing (4/25/77) in the White House. The timiug and logistics of the announcement have been arrauged to accomodate your participation if you so desire. We strongly recommend that you precede Secretary Califano's briefing with a few words to the press indicating your strong personal support for the cost coutainment program.

B. Additional Activity. A brief cover letter to each Governor and Member of Congress highlighting the legislation and urging their support is scheduled to go out over your siguature ou Monday morning, if you agree.

WATSON COMMENT

THE WHITE HOUSE

WASHINGTON

April 22, 1977

MEMORANDUM TO: THE PRESIDENT

FROM: Jack Watson
Jim Parham

SUBJECT: COMMENTS ON HEALTH MESSAGE

(1) We believe that the cost containment message would be more palatable to hospital interests if a paragraph such as the following were inserted (just before the concluding paragraph on hospital cost controls on page 5):

> "We are initiating our cost containment effort with hospitals becanse hospitals represent such a large share of our national medical service expenditure. We fully realize, of course, that hospitals comprise only one element of a large and complex health care system, and that it will be necessary to develop other cost containment measures."

(2) We suggest deletion of the sentence in paragraph three on page four which states:

> "It places no restrictions on the hospital's ability to determine its charges for any service."

Although the statement may be technically true, it is obvious that a ceiling on reimbursement levels has direct implications for charges. Some hospital advocates will consider the statement a gratuitous insult, and it is not needed for the rest of the paragraph's meaning to be clear.

(3) With regard to the CHAP program, we strongly concur with Stu's recommendation that we go forward with that part of the message.

(You might be interested to know that the HEW report on EPSDT for the final quarter of 1976 showed Georgia leading the nation in EPSDT screens for children. Approximately three out of every four children screened had conditions requiring referral for treatment. A major problem in follow-through is the low participation rate in Medicaid of physicians. The CHAP program has provisions which will encourage the development of comprehensive health care providers for children.)

BOURNE COMMENT

MEMORANDUM

THE WHITE HOUSE

WASHINGTON

April 22, 1977

TO: Rick Hutcheson

FROM: Peter Bourne P.B.

SUBJECT: Health Message

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- A specific statement should be included about the importance of consumers to actively involve themselves in state regulatory programs. The burden of respousibility to make the Health Systems Agencies operate effectively throughout the nation falls equally on providers and consumers. We should therefore, acknowledge and encourage the vital role which consumers play in containing rising hospital and other medical costs.

- Following up ou this theme, the statement should encourage all states to meet federal cost containment criteria embodied in the National Health Planning and Resources Development Act of 1974, which is being extended, thus encouraging a broader state authority without diminishing federal responsibility.

PGB:ss

Consumers & doctors
abuse use of
~~does~~ hospital facilities/services

THE WHITE HOUSE
WASHINGTON

Rick -

Bob Linder received the changes from Stu Eizenstat's office on Health Message --- from what he said it would appear that the last page will not have to be changed.

I made a copy of all the notes the President made on the cover memos --- I think we should keep the originals with handwriting, however, after our conversation the other day you might want to review what is being sent with the message to file.

Message sent as noted. Trudy

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Otherwise ok.

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FROM: Peter Bourne P.B.

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PGB:ss

Consumers & doctors
~~Hosp~~ abuse use of
hospital facilities/services

CALIFANO MEMO ON
COST CONTAINMENT

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

April 20, 1977

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Hospital Cost Containment Legislation

As your campaign and FY 1978 budget commitments emphasize, hospital cost containment legislation is essential because it will help restrain inflation and because it constitutes an important first step in devising a National Health Insurance bill that can be enacted by Congress. After extensive consultation with labor, business, providers, consumers, and federal, state and local officials, my staff and I have developed a cost containment proposal which can effectively hold down costs in the short-term. If this proposal had been in effect in 1976, we estimate hospital costs would have risen 10% instead of 15%, and $750 million would have been saved in Medicare and the Federal share of Medicaid.

In this memorandum, I will briefly describe the proposal's main features and discuss present political prospects. I am attaching a staff memorandum that presents the proposal in greater detail, surfaces possible arguments against the program, and rebuts those objections.

I. THE COST CONTAINMENT PROPOSAL: AN OVERVIEW

Purpose: The program aims to restrain hospital cost increases in the short-term by limiting hospital revenue increases to a minimum level recognizing general inflation and including a small increment to allow for added intensity of patient services.

Basic Method: Total hospital revenue would be restrained by limiting increases in payments from each third-party cost payer (Medicare, Medicaid, Blue Cross) and from charge payers (insurers and self-paying patients) as a class.

Coverage: The program would cover the inpatient revenues of short-term acute and specialty hospitals. It would exclude new hospitals (those less than 2 years old) and hospitals getting at least 75 percent of their revenue from a Federally defined Health Maintenance Organization.

How Revenues Would Be Restrained: Hospital revenue increases would be restrained by applying limits to average reimbursement per admission received from each of the major cost reimbursers (Medicare, Medicaid, Blue Cross) and to average charges per admission received from all charge payers (insurers and self-paying patients).

Administration of the program would be largely self-executing, using data routinely reported to the Medicare program.

Exceptions: Exceptions would be permitted on only two grounds:

(1) When there are exceptional changes in patient load (only 3 percent of all hospitals are expected to experience such changes); and

(2) When there are major changes in capital facilities, equipment, or new services and these changes are required to meet community health needs.

Adjustment for Non-Supervisory Workers: To avoid an inequitable impact on the earnings of low-wage workers, hospitals would be permitted an adjustment of the revenue limit based on actual increases in pay for nonsupervisory employees during the first eighteen months of the program. At the end of the 18 month period I would determine if the adjustment should be continued.

Waivers for State Programs: A hospital could receive a waiver from the Federal hospital cost containment program if the state in which it was located had in place for one year a comprehensive cost containment program which can be expected to fulfill the purposee of the Federal program.

Preventing Unwarranted Shifts of Poor Patients to Government Hospitals: The program will also include measures to prevent private, non-profit hospitals from refusing to treat poor and other charity cases in an attempt to meet revenue constraints.

Disclosure of Hospital Financial Data: Each hospitsl would be required to release data on its charge structure and cost reports filed with the government — local community health systems agencies (HSA) would periodically publish the charge data.

Limits on Capital Expenditures: In addition to short-term restraints on revenues, the Administration bill would control inappropriate capital expenditures in the hospital industry by establishing a national ceiling on new hospitsl capital investment which local health systems agencies can approve. The national limit would be allocated through a population based formula, and the Department would have authority to make adjustments in later years based on population movements, costs of construction and need for capital expansion or modernization. An HSA could not approve net additions to bed supply if there is excess capacity in the area.

II. POLITICAL PROSPECTS

We can expect support for your hospital cost containment proposal in the following quarters:

— We have been working closely with the leadership and staff of key House committees. Congressmen Rogers and Rostenkowski are expected to jointly introduce the bill, and will hold joint hearings the second week in May. On the Senate side, we have a slim chance for joint sponsorship from Senators Long or Talmadge and Kennedy (who is already committed to your approach in this area). All three are likely to introduce, but they may do so separately.

— State governments struggling with rapidly increasing Medicaid costs will provide strong support for your bill.

— Both Blue Cross and the commercial insurance companies generally favor the approach outlined above (although they still have differences of detail).

— Both big business and big labor are feeling the effects of rising hospital costs. With the wage pass-through we are recommending for nonsupervisory employees, labor will not oppose your legislation, although neither labor nor business is likely to campaign actively for government controls. Nonetheless, I have been meeting with selected business and labor leaders, as have members of my staff, and we may be able to develop more business and labor support than I initially thought possible.

— We anticipate generally favorable press reaction to your proposal. We have begun a press campaign -- that will soon be stepped up markedly -- to develop public support for short-term limits on hospital revenues and long-term reform of hospital service expansion, delivery and financing.

— Other sources of support include: etate rate setting commissions (where they exist), consumer groups, insurance commissioners, and selected hospital administrators.

On the other hand, most health care interests will oppose an Administration proposal, although in developing your program we have sought to minimize opposition from the AMA and other non-hospital groups.

Clearly, the most active, organized opponent of the bill will be the American Hospital Association. An AHA lobbying campaign against the proposal is already in full-swing. Officials of the Association have, however, indicated that they would be willing to accept restrictions on future capital growth. The AHA's support for certain provisions of the legislation can, I believe, be exploited because it will force Senators and Congressmen to become familiar with the bill in detail. My legislative staff has been working hard to persuade members not to comment negatively on hospital cost containment before your bill is introduced. But hospitals in each state will put significant pressure on individual members of Congress (one out of thirty employees in the United States works in a hospital).

In short, hospital cost containment legislation will not be enacted unless the Administration is willing to expend significant political energy. The precipitous rise in hospital costs is not a gut issue for most Americans because consumer resentment is primarily directed toward the mechanisms which pay for hospital cost increases -- taxes and insurance premiums -- rather than toward the cost increases themselves.

There is virtual unanimity among those to whom I and my staff have spoken about the issue: The Administration will have to make an all-out effort to secure passage of the proposed legislation. Your continued personal involvement will be necessary to counter the strong political pressure which the hospitals will mount and to mobilize adequate public and Congressional support.

Joseph A. Califano, Jr.

THE HOSPITAL COST CONTAINMENT PROGRAM: PROVISIONS, JUSTIFICATION & OBJECTIONS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

APRIL 20, 1977

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THE HOSPITAL COST CONTAINMENT PROGRAM:
PROVISIONS, JUSTIFICATION AND OBJECTIONS

I. Objective

The objective of the program is to restrain hospital cost increases by limiting hospital revenue increases in the short term and to establish a system of capital allocation to reduce creation of unneeded and duplicative hospital facilities and services.

II. Basic Method

Total hospital revenue would be constrained by limiting increases in payments from each third-party cost payor and from charge payors as a class.

Justification:

— Approach can be implemented and administered quickly and simply.

— It requires no new data collection or reporting forms and can be readily understood by the hospitals.

— It will provide immediate savings to the Medicare and Medicaid programs, to private insurance and the public.

— Future year savings will be even greater as hospital managers alter employee staffing patterns and become more cost conscious in expanding services and facilities.

Possible objection #1:

— Equal limits for both low-cost, efficient hospitals and those with inflated cost bases may be inequitable.

Rebuttal:

— This approach would be transitional—applied only for a short poriod of time (1 to 3 years), and would eventually be superseded by longer term methods which compare the costs of each hospital with those of similar hospitals as a basis for determining appropriateness of each hospital's cost base.

— Data and appropriate methodologies are not yet available to establish a sufficiently homogeneous grouping of hospitals to have reimbursement based on relative levels of efficiency and economy.

Possible objection #2:

— Price controls on the hospital industry, without limiting wage increases, or the prices of goods hospitals must purchase, places an unfair burden on hospitals.

Rebuttal:

-- The program limit would be set high enough to accommodate general economic price trends.

-- The program would allow a pass-through of higher wages for nonsupervisory workers during its first 18 months.

-- Special cost problems, such as medical malpractice premium increases, would be dealt with by separate Departmental actions, e.g. recognizing self-insurance funds as an allowable cost under Medicare.

-- The hospital industry is characterized by almost complete third-party insurance coverage, and cost-based reimbursement provisions. Thus, some special treatment is required.

-- Hospitals would still have considerable flexibility to set prices or affect utilization of services in order to come within the overall restraint.

-- The system also provides incentives for hospitals to obtain greater net revenues by reducing admissions through utilization review and PSRO. Further incentives could be included later to reward hospitals for closing beds, sharing services, merging, etc.

III. Coverage

The program would cover the inpatient revenues of short-term acute and specialty hospitals. It would exclude new (less than 2 years old) hospitals and those getting at least 75 percent of their revenue from Federally defined health maintenance organizations.

Justification:

-- Restriction to inpatient services is necessary because it is administratively difficult to measure and monitor outpatient visits.

-- Federal Government hospitals, although not specifically mentioned in the legislation, are already under budget constraints. Budgeting for their short-term acute inpatient units would be modified to reflect the overall national goal and to set an example for the private sector.

-- There is an inadequate data base for establishing revenue increase limits for new hospitals.

-- Exemption of hospitals dealing predominantly with Federally defined HMOs provides an added incentive for development of these proven efficient organizations.

-- Long-term and chronic care hospitals are excluded because they do not have the same inflationary problems as short-term hospitals.

Possible objection:

— Failure to cover the entire health sector will distort care patterns, shifting costs and services away from inpatient hospital care.

Rebuttal:

— The revenue limit would exclude from the base any inpatient services moved out of the hospital to avoid the controls.

— Outpatient treatment of a range of conditions can be performed at lower cost than inpatient care without lowering quality and is desirable.

— Bad debt ratios in outpatient departments are so high that hospitals have always tried to shift costs to the inpatient side.

— Expansion of outpatient facilities would still be subject to health planning review and capital limits, curbing any unwarranted growth.

Other considerations:

— Labor should be supportive of the exemption of HMO hospitals.

— Veterans might be alarmed by inclusion of VA hospitals, even for only part of their operations.

IV. Setting the Basic Limit

The basic limit would be set by a formula reflecting general economic price trends plus a small increment for expansion in services. The limit would be set equal to the annual percentage change in the implicit GNP price deflator lagged three months plus one-third of the difference between the average annual increase in total hospital expenditures and the GNP price deflator over the past two years.

Justification:

— A legislated formula based on a general economic price index plus an allowance for continued expansion of essential services should reassure hospitals that unreasonably low limits will not be set.

— Establishment of an appropriate level (or formula for obtaining level) in legislation reduces the likelihood of later hospital industry legal challenges on grounds of arbitrariness.

Possible objection:

— A general economic price index does not reflect the particular mix of goods and services purchased by hospitals.

Rebuttal:

— The current state of the art in developing hospital-specific input price indices is primitive. National level data for hospital-specific indices are not available.

— Allowing for trends in the prices of all goods and services in the economy should permit adequate recovery of hospital input price increases.

— The additional allowance for expansion of services provides a cushion to hospitals with above average increases in certain input prices.

V. Adjusting the Basic Limit for Changing Patient Load

The basic limit would be adjusted to reflect any major changes in patient load:

— Increases in total allowable revenue would remain constant in a first range where patient load, measured by admissions, changed by only a small amount in either direction.

— Revenue increases equal to 1/2 of average revenue per stay in the base year would be allowed for each increased admission beyond the first range.

— Similarly, revenue decreases equal to 1/2 of average revenue per stay would be imposed for decreased admissions.

— Finally, no additional revenue would be allowed for increased admissions beyond some point, and full revenue reduction would be imposed for decreased admissions, except for hospitals with fewer than 4,000 admissions in the previous year or for other hospitals upon approval by exception (about 3 percent of hospitals would be estimated to fall in this range).

Justification:

— Provides incentives for hospitals to identify and reduce unnecessary hospital utilization.

— Consistent with longer term cost containment methods such as prospective budgeting and area-wide limits on hospital expenditures.

— Permitting a 50 percent automatic adjustment in revenues for major changes in patient load reduces the incentive to increase or decrease admissions.

— The small hospital provision reduces the number of exceptions which would be filed; it does not seriously undercut the effectiveness of the overall constraint.

Possible objection #1:

-- Hospital administrators do not have direct control over admission of patients, length of stay, or tests ordered by physicians.

Rebuttal:

— Hospitals can influence admissions and length of stay through the establishment of utilization review committees, requirements on pre-admission certification, etc.

— Considerable anecdotal evidence exists to demonstrate that hospitals do, on occasion, attempt to "drum up business" through notices to medical staff and even direct advertising.

Possible objection #2:

— Varying hospital revenues according to changes in patient load would be complex, and create uncertainty detrimental to sound hospital management.

Rebuttal:

— A simple table indicating allowable revenues for any given change in patient load could be supplied to each hospital and third party payor, eliminating any confusion regarding the limit.

-- Good hospital management practices dictate establishment of a hospital budget in advance. This method reinforces such planning.

VI. Applying the Limit

The limit would be applied to the average reimbursement per stay paid by each cost reimburser (Medicaid, Medicare, Blue Cross) and to average billed charges per stay (commercial carriers and self-pay patients). Cost payors would estimate the limit per stay for purposes of interim reimbursement based on any anticipated changes in patient load and apply the actual limit in final settlement using final fiscal year data on actual changes in patient load. The Medicare intermediary would also determine any excess charges per stay for commercial carriers or self-pay patients, by dividing total billed charges by total admissions reflected in Medicare cost reports. If total charges per stay exceed the rate of increase allowed for the hospital, it would be required to reduce charge increases in the following year. Adequate public notice of the hospital's violation would be required. A hospital or third party that paid or retained revenues in violation of the program could be penalized and required to pay a tax to the U.S. Treasury equal to 150 percent of the amount in violation.

Justification:

— Applying the allowable percentage increase by major type of payor is administratively simple, permits each major third-party payor (Medicare, Medicaid, Blue Cross) to make final settlements without waiting for all other payors, and would not require any additional reporting forms or audit.

— Neutral with regard to the distribution of financial support by type of payor, neither favoring nor discriminating against any type of patient.

— Requiring hospitals to publicize any overcharges should be a significant deterrent to excess charge increases.

Possible objection #1:

— Establishing the limit by type of payor reduces the flexibility of hospitals to meet the overall constraint.

Rebuttal:

— That flexibility is desired more to avoid the restraint than to meet it. If allowed to, hospitals will discriminate in favor of those classes of patients who provide the highest net revenues (i.e., charge payors).

Possible objection #2:

— Requiring hospitals to carry forward excess charges is less satisfactory than having them actually pay back excess revenues.

Rebuttal:

— It will be difficult to identify who is actually entitled to the cash refund--insurer, patient, or employer. Therefore, a reduction of future charge increases combined with public disclosure of the violation is the preferred option.

Other considerations:

— Most States would be supportive of this approach. However, it would be opposed by those States with Medicaid waivers that now allow them to pay less than if they were following the Medicare rules.

— The commercial insurance companies will support this since it prevents a continued widening of the gap between costs and charges. Blue Cross should support it since it gives them a formal role in the program.

VII. Base for Application of the Limit

The base for the application of the revenue limit would be the revenue from each class of payor in the hospital accounting year ending in calendar year 1976 adjusted to the effective date of the cost containment program at a rate reflecting previous cost trends in the hospital, but not to exceed a specified rate or to fall below a minimum rate.

Justification:

— This method would assure that any hospital which raised charges or costs after public announcement of the Administration's hospital cost containment effort would not benefit from that action.

-- It would provide at least some small reward to hospitals with minimal or negative changes in hospital expenditures in the recent past.

Possible objection:

— Establishing a maximum rate penalizes hospitals introducing new capital facilities during the period from the end of the 1976 fiscal year and implementation of the program.

Rebuttal:

— Using previous cost trends from a period of generally high cost increases is a generous standard, and should not impose a heavy burden on hospitals.

VIII. Exceptions:

Exceptions would be permitted on only two grounds:

1) exceptional changes in patient load (anticipated to encompass about 3 percent of all hospitals); and

2) major changes in capital facilities, equipment, or new services.

Health planning agencies would review and comment on exceptions. To receive added revenues under any exception, a hospital would also have to demonstrate the unavailability of alternative funding to cover the added costs.

Requests for exceptions would have to be acted upon within 90 days of receipt by HEW or the hospital and third-party payors could presume approval.

Any hospital granted an exception would be subject to an operational review of effectiveness and efficiency by the HEW Audit Agency or its agents. The report of the HEW findings would be made public.

Justification:

— Limited criteria for exceptions are necessary to maintain the effectiveness and administrative simplicity of the program.

— Strong tests of community necessity for new services by health planning agencies and unavailability of financing for the operating costs of new facilities or services should ensure a limited number of exceptions.

Possible objection:

— Grounds for exceptions should be expanded to include general financial hardship and increased complexity of patient mix.

Rebuttal:

— The Federal government is not responsible for guaranteeing financial survival of inefficient or chronically underused hospitals.

— Patient mix does not change rapidly over time for either large or small hospitals. No adjustment for this factor is indicated in the short term.

— Changes in case-mix exceptions are administratively complex.

Other considerations:

— Teaching hospitals will object strenuously to the absence of an exception for changing case mix.

IX. Adjustment for Wage Increases of Nonsupervisory Employees:

During the first 18 months of the program, the allowable percentage increase in revenues would be adjusted, at the option of the hospital, to reflect the cost of wage increases granted to nonsupervisory workers. The adjusted limit would be based on the general limit for all costs other than wages of non-supervisory employees and on actual changes in wage rates for these employees. At the end of the 18 month period, the Secretary would determine if the adjustment should be continued.

Justification:

— Increases in the Federal minimum wage would make it difficult for hospitals to preserve parity arrangements and stay within the limit without this automatic adjustment.

-- Workers in the hospital industry should not be at a disadvantage relative to other workers.

— Cost savings would not be substantially reduced by such an adjustment.

Other considerations:

— This adjustment is extremely important to the labor movement.

-- It can be terminated by the Secretary if it is abused.

X. Maintenance of Effort

Hospitale would be required to maintain their Medicaid and charity patient load shares. Enforcement would be on the basis of investigation upon complaint by other area hospitals, health planning agencies, or the public.

Justification:

— There is some possibility that hospitals will seek to avoid the intent of the limits by replacing charity patients with those patients covered by insurance.

XI. Disclosure

Hospitals would be required to make available to the public, HSA, and third-party payors current charge schedules and cost reports. HSAs would have to publish comparative charge data periodically.

Justification:

— These provisions should enable consumers and other concerned parties to make more informed and cost conscious decisions.

XII. State Programs

A State could receive a waiver from the Federal cost containment program if its meets the following conditions:

a. There has been a hospital cost containment program in effect in the State for at least one year prior to the requested waiver;

b. That program included all payors in the State (except Medicare) and covered at least 90 percent of the hospitals that would be included in the Federal program;

c. The State agrees to comply, on an aggregate basis, with the basic Federal ceiling;

d. There is the expectation based on demonstrated performance that the State will achieve the Federal objective under its own program;

e. The State plan provides that any excess revenues generated will be returned to payors in an appropriate manner;

The requirement that all payors except Medicare were included in the State plan can be waived if the State has had a program covering at least 50 percent of total hospital payments for one year and the State adds all payors to its plan effective no later than the time of the requested waiver.

New State programs can be added over time, but only under the strict criteria of the experimental program of Section 222 of P.L. 92-603.

Justification:

— Eleven States have developed or are developing programs limiting payments to hospitals. Only four (Massachusetts, Connecticut, Maryland, and Washington) are now operational for all payors. Some recognition must be made of these States' efforts since the methods developed are typically more sophisticated and refined than the initial national effort.

— It also prevents new States from coming in with primitive or ill-conceived systems and pressuring the Department for a waiver.

— Governors should support the proposal with the above criteria included.

-- Labor is likely to oppose weak criteria for granting State waivers, as this would lay the basis for a major State role in the administration of hospital reimbursement under national health insurance.

XIII. Authority

Medicare would be required to comply with the program.

Cooperation of State Medicaid agencies and fiscal agents would be made a requirement of the State Medicaid plan.

Any hospital or third party payor that was found to have paid or retained funds in violation of the Act could be required to pay a penalty to the U.S. Treasury equal to 150% of the amount in violation.

HSAs would have to comply with requirements of this program or lose their designation and Federal funding under the Public Health Service Act.

Justification:

— The taxing power authority is a reasonable basis for the program since a principal goal of the program is the reduction of future Federal expenditures. Unless all hospital revenues are controlled, either Federal expenditures under Medicaid and Medicare will not be controlled, or hospitals will have an incentive to discriminate against Federal beneficiaries for whom they receive lower payments than private beneficiaries.

— Financial penalities are included to reduce the incentive of hospitals and insurers to pay or collect excess revenues which can then be rolled forward indefinitely.

Other considerations:

— The Supreme Court has ruled that hospitals of under 40 beds do not engage in interstate commerce. Therefore, using the commerce clause might result in new challenges to its applicability in larger "community" hospitals.

— Using the commerce clause would involve some committees in the Congress which have no special expertise in health and would strain relationships with the regular health committees.

XIV. Capital Expenditure Program

The program would annually set a national limit on new capital expenditures by acute care hospitals. The limit would be set at a level somewhat less than expenditures in previous years.

The national limit would be allocated to the States by a formula which would be based on population, with Departmental authority to adjust the allocation in later years to reflect population movements, cost of construction, and need for capital expansion or modernization. States would award new certificates of need to hospitals up to their limit. HSAs would assist the States by reviewing and commenting on applications for certificates. An HSA could not approve net additions to bed supply if the area had more than 4 beds per 1000 population or an average hospital occupancy less than 80%.

Medicare and Medicaid would deny reimbursement to hospitals which proceed with unapproved projects. The Federal government would operate the program in States which do not agree to participate.

Justification:

— A cost containment effort can only be effective over a long period of time if steps are taken now to slow the rate of growth of bed capacity and the duplication of expensive technology.

— An effective capital spending constraint will have further benefits by reducing the number of hospitals qualifying for exceptions in future years.

Other considerations:

— Hospitals generally favor this approach to cost containment since it curtails the supply of new hospitals in an area. However, hospital groups may push for passage of this portion, and rejection of the rest of the plan.

— This approach is likely to be supported by labor, so long as there are no cutbacks in construction currently underway.

CALIFANO MEMO ON
"CHAP" PROGRAM

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

April 20, 1977

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Child Health Initiative

In addition to hospital cost containment, your forthcoming health message will include a major new initiative for poor children -- the Child Health Assessment Program (CHAP). This memorandum describes the major features of that initiative and assesses the probable reaction to it.

THE PROPOSAL

Purpose: The initiative seeks to improve substantially (and rename) an existing Medicaid program for children entitled Early and Periodic Screening, Diagnosis and Treatment (EPSDT). In essence, CHAP will provide incentives, through the Federal match, that will encourage comprehensive health care providers to participate in the program and to assess, treat and monitor poor children with health problems.

Target Population: Medicaid eligibility is expanded to an additional 700,000 children for a total of 13 million children, not only in families that meet the State's income test for AFDC (as presently required), but also in two-parent families and in families with a working parent. Given the limited funds requested, the focus of our initial efforts will be on children under six. And the number of children who will receive preventive health assessments will be increased from 2-1/2 to 3 million in FY 1978.

Relationship to Immunization Initiative: Immunization against childhood diseases will be a required service for all children reached by this program.

Federal Match: The Federal share of program costs will increase from an average of 55 percent to 75 percent. Within three years assessment and primary care services must be given to children by primary health providers (i.e., primary care physicians or health care centers) to retain the higher match.

Net Fiscal Relief: Although there will be higher state costs in serving more children, these will be offset by increases in the Federal match. The net FY 1978 fiscal relief to the States should be $14 million.

Assistance for Resource Development: Making more children eligible for care will require increased treatment resources. The strikingly low assessment rate for children results, in large measure, from the lack of adequate personnel and facilities in areas of greatest need. Expanding treatment capacity at the same time funds for reimbursement are increased is essential to the success of the proposal. A sum of $25 million will be set aside to establish, expand, or improve health center services under the community health center program. Priority will be given to the establishment of health centers in areas with a shortage of comprehensive care providers participating in the CHAP program.

Penalties and Additional Incentives: A penalty will be assessed against the Federal share of Medicaid administrative costs for failure to inform families of the availability of assessments, to provide assessments when requested, or to provide treatment for conditions detected. The Federal match rate for administration will be increased when States meet performance standards such as the percent of eligible children assessed, the percent of detected conditions treated, and the percent of children fully immunized. The penalty provision of the old EPSDT program which was levied against AFDC funding will be dropped.

REACTION

We can anticipate support for this legislation from advocacy groups concerned with inadequate health care for poor children, and from organizations of health professionals. The American Academy of Pediatrics favors CHAP.

Those States which do not now serve the newly eligible children may react negatively. These include Illinois, Ohio, Texas, Georgia, and Florida. As noted, the fiscal impact on the States is mitigated, however, by increasing the Federal matching rate. States which benefit most from the increased match include New York, Michigan, New Jersey, and California.

We can also expect opposition -- primarily from State health departments -- to a provision which, after three years, eliminates funding for screening agencies that do not also provide treatment services. The Secretary may waive this provision if necessary to ensure continuing assessments in underserved areas.

There may be general criticism that we are adding a relatively modest sum of $180 million to the Medicaid program and using the EPSDT mechanism which has thus far reached only about 30 percent of eligible poor children. Our response is that this is a first step in covering more poor children using existing arrangements, and we look to national health insurance to bring about major reforms in delivery of health care to the poor and others not now served effectively.

On the other hand, Congressional reaction should be generally favorable. Both the increased Federal match and the focus on children under 6 and children in families with a working parent should be well received. Finally, the Congress should generally approve of the administrative incentives and the new money for resource development.

Congress will find the assistance for resource development especially attractive. Members know that it is necessary to build capacity in underserved areas at the same time that demand for services is being stimulated. Moreover, without this provision, the States will not view this new initiative to reach poor children as a serious, systematic effort on the part of the Federal government. This component of CHAP--which you have already approved and which accounts for 15% of its total cost--is thus an important part of the program, both symbolically and substantively.

Joseph A. Califano, Jr.

TO THE CONGRESS OF THE UNITED STATES:

This country spends more on health care than any other nation -- $160 billion this year, almost nine percent of our Gross National Product. We have the finest medical facilities and highly skilled, dedicated health professionals. Yet many of our people still lack adequate medical care, and the cost of care is rising so rapidly it jeopardizes our health goals and our other important social objectives.

I am transmitting to the Congress two major pieces of legislation to improve our health care system: The Hospital Cost Containment Act of 1977 to hold down rising health care costs, and the Child Health Assessment Program (CHAP) to improve health services for children of low-income families.

I. Hospital Cost Containment Act of 1977.

First, I am today proposing legislation which will limit the growth of the major component of health cost increases -- rising hospital expenditures. The Hospital Cost Containment Act will restrain increases in the reimbursements which hospitals receive from all sources: Medicare, Medicaid, Blue Cross, commercial insurers, and individuals. The limit will be set using a formula which not only reflects general inflation, but also extends to hospitals an additional allowance for improving their quality of care. Based on current trends, the limit for fiscal year 1978 will be approximately nine percent.

The legislation will also impose a limit on new capital expenditures for acute care hospitals. The program will fix a national level for such expenditures below that of recent years and allocate new capital spending among the states by formula. With the assistance of local planning agencies, each state will determine which facilities merit new capital expenditures.

Specifically, the Hospital Cost Containment Act of 1977 will:

-- Limit the in-patient reimbursements of acute care hospitals, excepting new hospitals, federal hospitals and Health Maintenance Organization (HMO) hospitals.

-- Provide an automatic formula to adjust the nine percent limit for moderate changes in expected patient load. The formula will contain strong incentives to discourage unnecessary hospitalization.

-- Include an adjustment for hospitals which provide wage increases to their non-supervisory employees.

-- Provide an exceptions process for the small percentage of hospitals which will undergo extraordinary changes in patient loads or major changes in capital equipment and services. The program will require the Department of HEW to respond to any application for an exception within 90 days.

-- Disallow in the computation of a hospital's base cost any unwarranted expenditures made in anticipation of the implementation of the program.

-- Allow states which operate cost containment programs, and are capable of meeting the federal program's criteria, to continue their own regulatory approaches.

This program will save ABOUT $2 [redacted] billion in fiscal year 1978 -- OVER $650 [redacted] million in the federal budget, OR $500 MILLION [redacted] in state and local budgets, and ALMOST $800 M... ON [redacted] in private health insurance and payments by individuals. IN [redacted] fiscal year ABO, [redacted] total savings will EXCEED $5.5 [redacted] billion.

These savings will slow a devastating inflationary trend, ~~The present rate of growth in health spending,~~ which doubles HEALTH [redacted] costs every five years, ~~harms each American.~~ This year health care will cost an average of over $700 for every man, woman, and child. Each worker's share of our Nation's health bill will require more than a month's work.

For the federal budget, rising health spending has meant a tripling of health outlays over the last eight years. Without immediate action, the Federal government's bill for Medicare and Medicaid -- which provide health care for our elderly and poor citizens -- will jump nearly 23 percent next year, to $32 billion.

Rising health costs attack state and local governments as well. State and local Medicaid expenditures have grown from $3 billion in 1971 to $7 billion in 1976, forcing cutbacks which harm the low income recipients of the program.

Unrestrained health costs also restrict our ability to plan necessary improvements in our health care system. I am determined, for example, to phase in a workable program of national health insurance. But with current inflation, the cost of any national health insurance program the Administration and the Congress will develop will double in just five years.

Finally, uncontrolled medical care spending undermines our efforts to establish a balanced health policy. Medical care is only one determinant of our people's health. The leading cause of death for Americans under 40 is motor vehicle accidents. The leading causes of death for older Americans -- heart disease and cancer -- are directly related to our working conditions and our eating, drinking, smoking, and exercise habits. We can better confront these broader health problems if we can limit the increase in soaring medical care costs.

Containing hospital cost increases is of central importance. Hospitals absorb 40 cents from each of our nation's health care dollars, and the cost of hospital service is rising faster than the cost of other health services. As in recent years, our country's total hospital bill this year will climb 15 percent -- to $64 billion.

Since 1950, the cost of a day's stay in the hospital has increased more than 1,000 percent -- over eight times the rise in the Consumer Price Index. Today, the average hospital stay costs over $1,300; just 12 years ago, a slightly shorter stay cost less than $300. This relentless increase places a severe burden on all of us -- and strikes hardest at the poor and the elderly.

To control escalating hospital costs, some have proposed to cap Medicare and Medicaid expenditures. Such a federal spending limit would encourage hospitals to reduce their services to low-income and elderly patients and to recoup rising expenses by increasing their charges to all other Americans. In contrast, the legislation I am proposing today reduces the growth in federal Medicare/Medicaid expenditures without imposing such severe new burdens on other purchasers of health services.

This legislation is not a wage-price control program. It places no restrictions on the hospital's ability to determine its charges for any particular service. It places no limit on the size of any wage demand or settlement. The program establishes an overall limit on the rate of increase in reimbursements, permitting doctors and hospital administrators to allocate their own resources efficiently, responding to local needs and individual circumstances.

This proposal relies heavily on the initiatives of the private sector. For it to succeed, businesses, unions, and insurers, working with providers, must continue to pursue innovative techniques for reducing the cost of high-quality health care. The private sector's response to the challenges of cost containment will help decide its future role in our health care system.

The federal sector must also hold down the costs of its own hospitals. The Administration will carefully review the operating and capital expenditures of federal health facilities,

Finally, consumers and producers can work together to reduce the unnecessary use of hospital facilities and services. By cutting down excessive utilization we help preserve our valuable resources and eliminate the risks we face when we undergo unnecessary treatment.

to insure that unwarranted increases do not occur. Further, we will eliminate unnecessary federal regulations which lead to increased costs for all hospitals.

Our hospital cost containment system is transitional. It is intended to flow directly into a long-term prospective reimbursement system, which will not accept a hospital's base cost as given. The long-term system will be able to analyze and compare base costs and provide greater incentives to those hospitals which are most efficient. The Congress and the Administration are already at work on this long-range system.

At the same time, I am committed to strengthening competition in the health industry. For example, we should encourage HMOs and other organizational arrangements which give providers an incentive to reduce costs, and we should encourage consumers to become more aware of the charges of different providers.

II. Child Health Assessment Program (CHAP).

The second piece of legislation I am proposing today, the CHAP Program,will replace Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) for children. The CHAP legislation, which calls for new expenditures of $180 million, will:

-- Raise from 55 percent to over 75 percent the average federal payment to the states for health care provided to children whose health needs are assessed nnder the program.

-- Extend benefits to children under age six whose family income level makes them eligible for assistance but who do not meet additional state eligibility requirements.

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-- Improve the federal program enforcement mechanism.

Like the cost containment program, the CHAP legislation is a crucial first step. Other children's health programs also require significant improvement, and the Administration will take steps to meet these needs. But the CHAP program is urgently needed to assure that more low-income children receive regular, high-quality primary and preventive care.

Currently, twelve million children are eligible for Medicaid, yet the EPSDT program is reaching only two million. Further, only slightly more than half of all children screened actually receive treatment for conditions that are identified. The CHAP program will assist the states in rectifying these deficiencies.

I call upon the Congress to act favorably on both of our new health initiatives.

THE WHITE HOUSE,

Letter to the Governors

THE WHITE HOUSE

WASHINGTON

April 22, 1977

To

I am writing to you today about the Hospital Cost Containment Act of 1977. I believe it is essential to the interests of all Americans. Although the problem of skyrocketing hospital costs is national in scope, its impact is felt most sharply on the state level. The solution will require your support and your active leadership to articulate the hardship the hospital cost spiral is imposing on your state's people.

The Hospital Cost Containment Act of 1977 will establish sound, administrable, transitional restraints on hospital costs until permanent reforms in health care delivery and financing can be implemented. In its first year, the program will save over $[redacted] million for state and local governments. Without such legislation, our present financing mechanisms, public and private, may break down under the pressure of annual increases in hospital costs of 15 percent or more.

Our health system requires permanent reforms, such as reimbursement methods that do more than simply respond to costs incurred, effective utilization controls, and greater emphasis on primary and preventive care. But the need for forceful, effective action in the short-term is clear and compelling. Indeed, without immediate action, some crucial reforms may not be possible. The enclosed material explains in detail the provisions of the legislation and the urgent need for this bill.

I strongly believe that hospital cost containment legislation is essential, and I urge you to support the Hospital Cost Containment Act of 1977. Together we can address a major national problem that demands an immediate solution, and I hope I can count on your leadership in that effort.

Sincerely,

Governor
State of

-House Letter

THE WHITE HOUSE

WASHINGTON

April 22, 1977

TO (first and last name) (no punctuation)
~~Dear~~

Your colleagues Paul Rogers and Dan Rosteknowski are today introducting the Hospital Cost Containment Act of 1977. I am writing to you about this bill because I believe it is essential to the interests of all Americans.

This legislation will establish shound, administrable, and transitional restraints on skyrocketing hospital costs until permanent reforms on health care delivery and financing can be implemented. Without such legislation, our present financing mechanisms, public and private, may break down under the presaure of annual increases in hospital costs of 15 percent or more.

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I strongly believe that hospital cost containment legislation is essential, and I urge you to support the Hospital Cost Containment Act of 1977.

Sincerely,

The Honorable
~~Congressman~~ _____
House of Representatives
Washington, D.C.

Senate Letter

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Sincerely,

The Honorable _____
United States Senate
Washington, D.C.

THE WHITE HOUSE
WASHINGTON

April 22, 1977

Midge Costanza
Bob Lipshutz
Frank Moore
Jack Watson
Jody Powell

For your information the attached message will be going to the President today for signature.

Rick Hutcheson

TO THE CONGRESS OF THE UNITED STATES:

This country spends more on health care than any other nation -- $160 billion this year, almost nine percent of our Gross National Product. We have the finest medical facilities and highly skilled, dedicated health professionals. Yet many of our people still lack adequate medical care, and the cost of care is rising so rapidly it jeopardizes our health goals and our other important social objectives.

I am transmitting to the Congress two major pieces of legislation to improve our health care system: The Hospital Cost Containment Act of 1977 to hold down rising health care costs, and the Child Health Assessment Program (CHAP) to improve health services for children of low-income families.

I. Hospital Cost Containment Act of 1977.

First, I am today proposing legislation which will limit the growth of the major component of health cost increases -- rising hospital expenditures. The Hospital Cost Containment Act will restrain increases in the reimbursements which hospitals receive from all sources: Medicare, Medicaid, Blue Cross, commercial insurers, and individuals. The limit will be set using a formula which not only reflects general inflation, but also extenda to hoapitals an additional allowance for improving their quality of care. Based on current trends, the limit for fiscal year 1978 will be approximately nine percent.

The legislation will also impose a limit on new capital expenditures for acute care hospitals. The program will fix a national level for such expenditures below that of recent years and allocate new capital spending among the states by formula. With the assistance of local planning agencies, each state will determine which facilities merit new capital expenditures.

Specifically, the Hospital Cost Containment Act of 1977 will:

-- Limit the in-patient reimbursements of acute care hospitals, excepting new hospitals, federal hospitals and Health Maintenance Organization (HMO) hospitals.

-- Provide an automatic formula to adjust the nine percent limit for moderate changes in expected patient load. The formula will contain strong incentives to discourage unnecessary hospitalization.

-- Include an adjustment for hospitals which provide wage increases to their non-supervisory employees.

-- Provide an exceptions process for the small percentage of hospitals which will undergo extraordinary changes in patient loads or major changes in capital equipment and services. The program will require the Department of HEW to respond to any application for an exception within 90 days.

-- Disallow in the computation of a hospital's base cost any unwarranted expenditures made in anticipation of the implementation of the program.

-- Allow states which operate cost containment programs, and are capable of meeting the federal program's criteria, to continue their own regulatory approaches.

This program will save $2.4 billion in fiscal year 1978 -- $800 million in the federal budget, $400 in state and local budgets, and $1.2 billion in private health insurance and payments by individuals. By fiscal year 1979, total savings will approach $5 billion.

These savings will slow a devastating inflationary trend. The present rate of growth in health spending, which doubles costs every five years, harms each American. This year health care will cost an average of over $700 for every man, woman, and child. Each worker's share of our Nation's health bill will require more than a month's work.

For the federal budget, rising health spending has meant a tripling of health outlays over the last eight years. Without immediate action, the Federal government's bill for Medicare and Medicaid -- which provide health care for our elderly and poor citizens -- will jump nearly 23 percent next year, to $32 billion.

Rising health costs attack state and local governments as well. State and local Medicaid expenditures have grown from $3 billion in 1971 to $7 billion in 1976, forcing cutbacks which harm the low income recipients of the program.

Unrestrained health costs also restrict our ability to plan necessary improvements in our health care system. I am determined, for example, to phase in a workable program of national health insurance. Bnt with current inflation, the cost of any national health insurance program the Administration and the Congress will develop will double in just five years.

Finally, uncontrolled medical care spending undermines our efforts to establish a balanced health policy. Medical care is only one determinant of our people's health. The leading canse of death for Americans under 40 is motor vehicle accidents. The leading causes of death for older Americans -- heart disease and cancer -- are directly related to our working conditions and our eating, drinking, smoking, and exercise habits. We can better confront these broader health problems if we can limit the increase in soaring medical care costs.

Containing hospital cost increases is of central importance. Hospitals absorb 40 cents from each of our nation's health care dollars, and the cost of hospital service is rising faster than the cost of other health services. As in recent years, our country's total hospital bill this year will climb 15 percent -- to $64 billion.

Since 1950, the cost of a day's stay in the hospital has increased more than 1,000 percent -- over eight times the rise in the Consumer Price Index. Today, the average hospital stay costs over $1,300; just 12 years ago, a slightly shorter stay cost less than $300. This relentless increase places a severe burden on all of us -- and strikes hardest at the poor and the elderly.

To control escalating hospital costs, some have proposed to cap Medicare and Medicaid expenditures. Such a federal spending limit would encourage hospitals to reduce their services to low-income and elderly patients and to recoup rising expenses by increasing their charges to all other Americans. In contrast, the legislation I am proposing today reduces the growth in federal Medicare/Medicaid expenditures without imposing such severe new burdens on other purchasers of health services.

This legislation is not a wage-price control program. It places no restrictions on the hospital's ability to determine its charges for any service. It places no limit on the size of any wage demand or settlement. The program establishes an overall limit on the rate of increase in reimbursements, permitting doctors and hospital administrators to allocate their own resources efficiently, responding to local needs and individual circumstances.

This proposal relies heavily on the initiatives of the private sector. For it to succeed, businesses, unions, and insnrers, working with providers, must continue to pursue innovative techniques for reducing the cost of high-quality health care. The private sector's response to the challenges of cost containment will help decide its future role in our health care system.

The federal sector must also hold down the costs of its own hospitals. The Administration will carefully review the operating and capital expenditures of federal health facilities,

to insure that unwarranted increases do not occur. Further, we will eliminate unnecessary federal regulations which lead to increased costs for all hospitals.

Our hospital cost containment system is transitional. It is intended to flow directly into a long-term prospective reimbursement system, which will not accept a hospital's base cost as given. The long-term system will be able to analyze and compare base costs and provide greater incentives to those hospitals which are most efficient. The Congress and the Administration are already at work on this long-range system.

At the same time, I am committed to strengthening competition in the health industry. For example, we should encourage HMOs and other organizational arrangements which give providers an incentive to reduce costs, and we should encourage consumers to become more aware of the charges of different providers.

II. Child Health Assessment Program (CHAP).

The second piece of legislation I am proposing today, the CHAP Program will replace Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) for children. The CHAP legislation, which calls for new expenditures of $180 million, will:

-- Raise from 55 percent to over 75 percent the average federal payment to the states for health care provided to children whose health needs are assessed under the program.

-- Extend benefits to children under age six whose family income level makes them eligible for assistance but who do not meet additional state eligibility requirements.

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THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR: THE PRESIDENT

FROM: STU EIZENSTAT
JOE ONEK
BOB HAVELY

SUBJECT: Health Message

Attached is the health message, summaries of the hospital cost containment and children's health legislation, and memoranda from Secretary Califano containing analyses of the two bills. Our views below incorporate OMB's positions and analysis. The message has been reviewed and improved by Jim Fallows' staff and has been approved by HEW.

I. Cost Containment.

Forty percent of all health spending goes for hospitalization. Hospitals are by far the largest component of the health sector, as well as the fastest growing (15 percent per year, as opposed to the annual CPI increase of six percent). While a long-term prospective reimbursement system is being prepared, the cost containment program will restrain increases in the reimbursements which hospitals receive from all sources: Medicare, Medicaid, Blue Cross, commercial insurers, and individuals. The limit will be set using a formula which not only reflects general inflation, but also extends an additional allowance to hospitals for improving the quality of their care. Based on current trends, the limit for FY 1978 will be approximately nine percent.

The legislation also establishes a limit on new capital investment by hospitals. This limit will be allocated to the states through a population-based formula. Further, the construction of new hospital beds will be prohibited in areas where excess bed capacity exists. These capital expenditure provisions will have little or no FY 1978 budget impact, but they are crucial to long-term cost containment.

A. Wage Pass-through. The legislation contains a pass-through for all wage increases above the nine percent limit granted to non-snpervisory employees. The pass-through terminates in 18 months, unless the Secretary of HEW certifies that it should continue. Organized labor demanded a wage pass-through, and threatened to oppose the bill if such a provision were not included. CEA Chairman Schultze originally opposed the pass-through as inconsistent with the Administration's anti-inflation policy, but he has since withdrawn his objection.

The wage pass-through will allow hospitals to collect increased reimbursements to a small, but not precisely predictable, extent. In addition, its presence may generate pressure on the Hill for other pass-throughs -- for energy costs, for example. On balance, however, we believe the advantage of avoiding union opposition to our entire cost containment effort is worth these risks. OMB also believes that although the pass-through lacks programmatic merit, it is politically necessary.

B. The Role of the States. The hospital reimbursement limit will be administered by the federal government. The few states with on-going cost containment programs will be able to continue their own regulatory approaches if they meet the federal program's objectives. The states will also play major roles in the exceptions process and in allocating capital expenditures. Further, the legislation permits states to impose limits on Medicaid more rigorous than the federal limitations. Any greater state role would encounter organized labor's antipathy toward state regulation. Although some Governors may argue for a broader state role, we believe the federal/state balance in the bill is correct, both substantively and politically.

II. Child Health Assessment Program (CHAP).

You have previously approved the broad outlines of the CHAP program, which modifies the existing EPSDT program. HEW's specific legislative proposal is within the estimates in your 1978 budget. The legislation would raise from 55 percent to over 75 percent the average federal payment to the states for health care provided to children whose health needs are assessed under the program. Second, it extends benefits to children under age six whose family income makes them eligible for assitance but who do not meet additional state eligibility requirements. Finally, it encourages states to aasure the availability of comprehensive health providers for low-income children. Projected FY 1978 cost: $155 million; FY 1981: $382 million.

A. Limited Extension of Eligibility. The legislation extends eligibility only to low-income children under age six. However, if eligibility were extended to all low-income children under age 21, this change would add $120 million to the federal budget in 1978 and approximately $40 million to state Medicaid budgets. OMB is concerned that the Congress may pass this extension, thereby increasing federal expenditures in 1978 through 1981. HEW counters that this is unlikely because the states will strenuously object, and because the Congressional budget limits will make such additions difficult. We believe HEW is correct.

B. Other Issues. OMB also points out that the HEW proposal commits the federal government to a 75 percent match for certain Medicaid services, and is concerned that this step will be a precedent for a higher federal share for all Medicaid services. OMB would like to consider alternatives, such as an annual $180 million children's health grant program to the states. You have previously approved this increased match.

C. Summary. OMB suggests that the health message either exclude reference to CHAP, or refer only generally to it and allow time for additional work on the program. However, unless we go forward with CHAP the Administration's health initiatives will be limited to cost containment. Furthermore, given the Congressional budget deadlines, little additional time remains in any case for further work on the program.

HEW maintains that this program is necessary to fulfill an important commitment of yours. While this legislation and the process that produced it have been far from perfect, we agree. We believe OMB's objections are not major, and suggest we proceed with the health message with the CHAP program intact.

III. Procedures.

A. Press Briefing. Current plans call for Secretary Califano to announce these programs Monday morning (4/25/77) in the White House. The timing and logistics of the announcement have been arranged to accomodate your participation if you so desire. We strongly recommend that you precede Secretary Califano's briefing with a few words to the press indicating your strong personal support for the cost containment program.

B. Additional Activity. A brief cover letter to each Governor and Member of Congress highlighting the legislation and urging their support is scheduled to go out over your signature on Monday morning, if you agree.

MEMORANDUM

THE WHITE HOUSE

WASHINGTON

April 22, 1977

TO: Rick Hutcheson

FROM: Peter G. Bourne P.B.

SUBJECT: President's Health Message

I would like an opportunity to review the President's health message as soon as possible.

PGB:ss

FOR IMMEDIATE RELEASE APRIL 25, 1977

Office of the White House Press Secretary

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THE WHITE HOUSE

TO THE CONGRESS OF THE UNITED STATES:

This country spends more on health care than any other nation -- $160 billion this year, almost nine percent of our Gross National Product. We have the finest medical facilities and highly skilled, dedicated health professionals. Yet many of our people still lack adequate medical care, and the cost of care is rising so rapidly it jeopardizes our health goals and our other important social objectives.

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The legislation will also impose a limit on new capital expenditures for acute care hospitals. The program will fix a national level for such expenditures below that of recent years and allocate new capital spending among the states by formula. With the assistance of local planning agencies, each state will determine which facilities merit new capital expenditures.

Specifically, the Hospital Cost Containment Act of 1977 will:

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more

(OVER)

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-- Allow states which operate cost containment programs, and are capable of meeting the federal program's criteria, to continue their own regulatory approaches.

This program will save about $2 billion in fiscal year 1978 -- over $650 million in the federal budget, over $300 million in state and local budgets, and almost $900 million in private health insurance and payments by individuals. In fiscal year 1980, total savings will exceed $5.5 billion.

These savings will slow a devastating inflationary trend, which doubles health costs every five years. This year health care will cost an average of over $700 for every man, woman, and child. Each worker's share of our Nation's health bill will require more than a month's work.

For the federal budget, rising health spending has meant a tripling of health outlays over the last eight years. Without immediate action, the Federal government's bill for Medicare and Medicaid -- which provide health care for our elderly and poor citizens -- will jump nearly 23 percent next year, to $32 billion.

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Unrestrained health costs also restrict our ability to plan necessary improvements in our health care system. I am determined, for example, to phase in a workable program of national health insurance. But with current inflation, the cost of any national health insurance program the Administration and the Congress will develop will double in just five years.

Finally, uncontrolled medical care spending undermines our efforts to establish a balanced health policy. Medical care is only one determinant of our people's health. The leading cause of death for Americans under 40 is motor vehicle accidents. The leading causes of death for older Americans -- heart disease and cancer -- are directly related to our working conditions and our eating, drinking, smoking, and exercise habits. We can better confront these broader health problems if we can limit the increase in soaring medical care costs.

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At the same time, I am committed to strengthening competition in the health industry. For example, we should encourage HMOs and other organizational arrangements which give providers an incentive to reduce costs, and we should encourage consumers to become more aware of the charges of different providers.

Finally, all of us -- consumers and providers -- must work together to reduce the unnecessary use of hospital facilities and services. By cutting down excessive utilization we can help preserve our valuable resources.

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-- Improve the federal program enforcement mechanism.

Like the cost containment program, the CHAP legislation is a crucial first step. Other children's health programs also require significant improvement, and the Administration will take steps to meet these needs. But the CHAP program is urgently needed to assure that more low-income children receive regular, high-quality primary and preventive care.

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I call upon the Congress to act favorably on both of our new health initiatives.

JIMMY CARTER

THE WHITE HOUSE,

April 25, 1977.

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